Chapter 7

Billing on the ADA 2002 Claim Form

INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that dentists bill for services on the ADA 2002 claim form. Dental claims for dates of service on and after January 1, 2004 must be billed on the ADA 2002 form. Claims billed on a CMS 1500 claim form for dates of service on and after January 1, 2004 will be denied.

NOTE: This chapter applies to paper ADA 2002 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at www.ahcccs.state.az.us. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

COMPLETING THE ADA 2002 CLAIM FORM

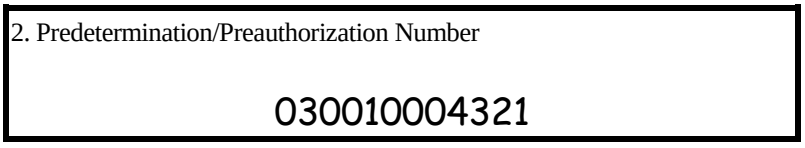
The following instructions explain how to complete the ADA 2002 Claim Form and whether a field is "Required," "Required if applicable," or "Not required."

1. Type of Transaction **Not required**

2. Predetermination/Preauthorization Number **Required if applicable**

Enter the appropriate code ("A" or "V") to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No."

See Chapter 4, General Billing Rules, for information on resubmissions, adjustments, and voids.



3. Primary Payer Name and Address **Required if applicable**

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

4. Other Dental or Medical Coverage **Required**

Check appropriate box to indicate whether recipient has third party coverage.

4. Other Dental or Medical Coverage?	☒ No (Skip 5-11)	☐ Yes (Complete 5-11)

5. Subscriber Name **Required if applicable**

6. Date of Birth **Required if applicable**

7. Gender **Required if applicable**

8. Subscriber Identifier **Required if applicable**

9. Plan/Group Number **Required if applicable**

10. Relationship to Primary Subscriber **Required if applicable**

11. Other Carrier Name, Address **Required if applicable**

12. Primary Subscriber Name and Address **Required**

Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card. Enter the recipient's address

12. NAME (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Earp, Wyatt H.
123 E. OK Corral Drive
Tombstone, AZ 85638

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

13. Date of Birth **Required**

Enter the recipient's date of birth.

13. Date of Birth
08/14/1851

14. Gender **Required**

Check the appropriate box to indicate the patient's gender.

14. Gender
M ☒ F ☐

15. Subscriber Identifier **Required**

Enter the recipient's *AHCCCS ID number*. Contact the AHCCCS Verification Unit if there are questions about eligibility or the AHCCCS ID number. (See Chapter 2, Recipient Eligibility and Enrollment).

15. Subscriber Identifier (SSN or ID#)
A12345678

16. Plan/Group Number **Not required**

17 Employer Name **Not required**

18. Relationship to Primary Subscriber **Not required**

19. Student Status **Not required**

20. Name **Not required**

21. Date of Birth **Not required**

22. Gender **Not required**

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

23. Patient ID/Account Number **Required**

This is a number that you have assigned to uniquely identify this claim in your records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and your own accounting or tracking system.

23. Patient ID/Account # (Assigned by Dentist)
WEARP5678

24. Procedure Date **Required**

Enter the procedure date in MM/DD/YYYY format.

	24. Procedure Date (MM/DD/CCYY)	25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

25. Area of Oral Cavity **Required**

Enter the code for the area of the oral cavity. Consult ANSI/ADA/ISO Specification No. 3950 *Designation System for Teeth and Areas of the Oral Cavity* for codes.

	24. Procedure Date (MM/DD/CCYY)	25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

26. Tooth System **Required**

Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation system. Enter "JO" when using ANSI/ADA/ISO Specification No. 3950.

	24. Procedure Date (MM/DD/CCYY)	25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

27. Tooth Number(s) or Letter(s) **Required**

Enter the tooth number when the procedure directly involves a tooth. Use commas to separate individual tooth numbers. If a range of teeth is involved, use a hyphen to separate the first and last tooth in the range.

	24. Procedure Date (MM/DD/CCYY)	25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

28. Tooth Surface **Required**

Designate tooth surface(s) when the procedure directly involves one or more tooth surfaces.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee	

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

29. Procedure Code **Required**

Enter the appropriate procedure code from the *CDT-4 Manual*.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee

30. Description **Required**

Enter the description of the procedure code billed in Field 29.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee

31. Fee **Required**

Enter the fee for the procedure code billed in Field 29.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee

32. Other Fees **Not required**

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

33. Total Fee **Required**

Enter the total of all fees in Field 31.

32. Other Fee(s)			
33. Total Fee			

34. Missing Teeth **Required**

Mark all missing teeth.

MISSING TEETH INFORMATION	Permanent	
34. (Place an 'X' on each missing tooth)	1 2 X 4 5 6 7 8	9 10 11 12 13 14 15 16
	32 31 30 29 28 22 26 25	24 23 22 21 20 19 18 17

35. Remarks **Not required**

36. Parent/Guardian Signature and Date **Not required**

37. Subscriber Signature and Date **Not required**

38. Place of Treatment **Required**

Check the appropriate box.

38. Place of Treatment (Check applicable box)
☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures **Required if applicable**

40. Is Treatment for Orthodontics? **Required if applicable**

41. Date Appliance Placed **Required if applicable**

42. Months of Treatment Remaining **Required if applicable**

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

43. Replacement of Prosthesis **Required**

Check the appropriate box. If "Yes" is checked, complete Field 44.

43. Replacement of Prosthesis?
☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement **Required if applicable**

If "Yes" is checked in Field 43, enter the date of prior placement in MM/DD/YYYY format.

45. Treatment Resulting From **Required if applicable**

Check the appropriate box, as applicable.

46. Date of Accident **Required if applicable**

Enter the date in MM/DD/YYYY format.

47. Auto Accident State **Required if applicable**

Enter the name of the state where the accident occurred.

48. Billing Dentist/Dental Entity Name and Address **Required**

Enter the name and address of the billing dentist or dental entity.

48. Name, Address, City, State, Zip Code
Holliday, John H.
123 E. Main Street
Scottsdale, AZ 85252

49. Provider ID (Group) **Required**

Enter the AHCCCS provider ID of the billing dentist or dental entity.

49. Provider ID
654321

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

50. License Number **Required**

Enter the license number of the billing dentist or dental entity.

50. License Number
987-654321

51. SSN or TIN **Required**

Enter the Social Security Number or tax ID number of the billing dentist or dental entity.

51. SSN or TIN
123-45-6789

52. Phone Number **Not required**

53. Signature of Treating Dentist **Required**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures

Signed (Treating Dentist) Date

54. Provider ID **Required**

Enter the AHCCCS provider ID of the treating dentist.

54. Provider ID
654321

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

55. License Number **Required**

Enter the license number of the treating dentist.

55. License Number

987-654321

56. Address (Treating Dentist) **Not required**

57. Phone Number (Treating Dentist) **Not required**

58. Treating Provider Specialty **Not required**